Professional identity in nursing: UK students' explanations for poor standards of care

Abstract

Research concludes that professional socialisation in nursing is deeply problematic because new recruits start out identifying with the profession's ideals but lose this idealism as they enter and continue to work in the profession. This study set out to examine the topic focussing on the development of professional identity. Six focus groups were held with a total of 49 2nd and 3rd year BSc nursing students studying at a university in London, UK and their transcripts were subject to discourse analysis. Participants' talk was strongly dualistic and inflected with anxiety. Participants identified with caring as an innate characteristic. They described some qualified nurses as either not possessing this characteristic or as having lost it. They explained strategies for not becoming corrupted in professional practice. Their talk enacted distancing from 'bad' qualified nurses and solidarity with other students. Their talk also featured cynicism. Neophyte nurses' talk of idealism and cynicism can be understood as identity work in the context of anxiety inherent in the work of nurses and in a relatively powerless position in the professional healthcare hierarchy.

Keywords: United Kingdom; nurses; anxiety; care and compassion; discourse analysis; focus groups; professional identity

Introduction

The accepted view in research on professional socialisation in nursing is that neophytes enter the profession with an idealised view of nursing work, which most lose (Maben et al., 2007; Mackintosh, 2006). Central to this ideal is that nursing is a profession characterised

by its caring and compassion toward patients and that this is the core of the professional's personal satisfaction. Researchers argue that neophytes are made anxious by their witness of the healthcare environment as well as experienced nurses' behaviour within it. Faced with this, they learn to develop approaches to their professional practice that allow them to maintain their ideals or abandon them to varying extents. This paper presents an analysis of focus groups comprised of UK nursing students. Reflecting on their experiences during placements in the UK National Health Service (NHS) the students talk about motivations for entering professional training, their experiences of witnessing poor care and their anxieties about the potentially corrupting effect of entering a professional nursing career. Our analysis questions previous research on socialisation in nursing by suggesting that talk of ideals and disillusion can be understood in terms of identity work. We therefore examine the discursive aspects of student nurses' developing professional identity.

We first contextualise our study by comparing research on the socialisation of new entrants in medicine and nursing carried out by researchers within these professions and by those who are not. We frame this with a summary of literature that focuses on professional identity as an interactional accomplishment. We do this to show how such an approach can help us avoid taking the accounts of professionals at face value. In terms of topic, we focus on literature that examines the anxiety that entry into the healthcare workplace can cause neophytes and their responses to this in terms of developing professional identity.

Developing professional identity in medicine and nursing

Professional socialisation has been described as ‘a complex interactive process by which the content of the professional role (skills, knowledge, behaviour) is learned and the values, attitudes and goals [such as concern for patients and a commitment to their well-being] integral to the profession and sense of occupational identity which are characteristic of a member of that profession are internalised’ (Goldenberg & Iwasiw, 1993). It is generally accepted that professional socialisation involves both explicit teaching and informal learning (Davis, 1975) as well as less comfortable features and subtly coercive practices (Apker & Eggly, 2004). The study of institutional talk has a long history, and in particular, studies of medical work and identity (Atkinson, 1995; Atkinson & Heath, 1981). Much of this work focuses on doctor-patient interactions e.g. (Drew & Heritage, 1992). A small number of studies focus on the discursive aspects of identity formation among the healthcare professions. For example, Frost and Regehr describe how Canadian medical students construct identity in the context of a tension between prevailing discourses of individuality and standardisation in medicine (Frost & Regehr, 2013). The authors of many studies understand professional education as a period of transition involving the forging of a new professional identity in conditions of considerable pressure and anxiety for neophytes. For example, a study by Apker and Eggly (2004) presents analysis of transcripts of ‘morning report’, public medical teaching sessions in which senior doctors and educators respond to case presentations by medical students. The researchers argue that these sessions operate as a disciplinary mechanism to reproduce medical ideology and a particular form of medical identity that marginalises the ‘lifeworld’ of patients and medical students and privileges a biomedical model of practice.

The most well-known and seminal research into the development of professional identity in the healthcare professions is probably Becker et al.'s *Boys in White* (1961). Becker and his colleagues' close attention to the experiences and concerns of medical students as they learned how to be 'medical men' in a US medical school during the 1950s has set the tone for much subsequent work. This is both in terms of the qualitative character of much research that followed as well as in its attention to informal learning, what Becker *et al.* referred to as 'a person's ordinary way of thinking and feeling about and acting in… a [problematic] situation' (page 34). This acting included, in their research, the example of a student faking laboratory blood test results in order to avoid the fearful censure of a senior medical figure and, in the long term, to pass the course and enter the profession. Vulnerability and fear are part of the socialisation process in Becker *et al.*'s research in which a lay identity or sense of the self is disassembled in a way that facilitates the subsequent building of a coherent professional identity and maintains the stability of the social structure of the professions. We will return to the proposition that vulnerability and fear are essential mechanisms of socialisation rather than unfortunate side effects later in this paper.

Much of the literature specifically about the developing professional identity of nursing students emphasises a similar disorientating disassembly of a lay understanding of nursing work (see below). The shock of witnessing the sometimes traumatic events of the healthcare environment alongside seeing how experienced professional nurses behave results in anxiety and dissonance for individuals, though the elements constituting this dissonance vary from study to study. For Melia (1987), the dissonance is between the theoretical version of nursing presented in the classroom and hospital versions of nursing

partaken in by students. For other authors it is between what they term professional idealism and practice realism (Curtis et al., 2012; Mackintosh, 2006). Curtis and colleagues for example focus on ‘compassionate practice’ which they identify as a core professional value and essential part of nursing’s identity. They investigated how 19 student nurses at a single university considered the value of compassionate care and their own ability to deliver this once they were qualified. For the student participants as well as the authors of the research it is the context of care delivery that imposes constraints on what they describe as being empathetic, holistic and doing what is right for the patient. The students pointed to lack of time and high patient throughput as frustrating their desire to be involved in these kinds of ‘compassionate’ activities. The personal satisfaction that these students anticipated - as being a part of the nurses’ identity - is aligned with professional ideals by the students and the authors. The ability to embody these ideals is blocked by the organisation of work that features high patient throughput combined with the practice of delegating some patient care to assistant grade workers and so losing the opportunity to develop ‘holistic’ relationships with patients. The authors described the students as having a sense of vulnerability in the face of constraints beyond their control and as concerned about reconciling their desire to ‘fit in’ to the workplace and their desire to maintain their initial idealism.

Some authors suggest that the way in which professional identity develops can have what they understand as ‘negative consequences for nurses’ (Mackintosh, 2006 page 953). For example, Mackintosh (2006) and Greenwood (1993) both see socialisation as leading to desensitisation toward patients. They see this as a result of students experiencing the apparent widespread cynicism of experienced nurses alongside their own anxiety about dealing with patient suffering. Mackintosh’s careful analysis describes her participants

falling into two groups by the end of training: those who totally rejected the apparent failure to care they had witnessed among staff during their training and those who recognised that some degree of emotional desensitisation was essential to preserve themselves in an environment that was often distressing because of the nature of the work. For her participants the dichotomy is between ‘working from the heart’ and not ‘bursting into tears every time somebody dies’ (Mackintosh, 2006 p 958).

Maben and colleagues’ work on the effects of time and experience on newly qualified UK nurses’ idealism (Maben et al., 2007) also finds different responses to the work environment. Maben *et al.*’s design involved collecting qualitative data from a sample in their last year of study in three UK universities, shortly after qualification and three years after qualification. At the start of the study she describes respondents as expressing a ‘strong set of espoused ideals around delivering high quality, patient-centred, holistic and evidence-based care’ (Maben et al., 2007 p. 99), which she describes as consistent with the profession’s mandate—in other words these students are understood as ‘idealists’. At the end of the study she classifies three types of respondents: sustained idealists, compromised idealists and crushed idealists. The work of professional socialisation is explicit in this study with an apparent agreement among the students that their formal training had shaped their thinking in ways consistent with nursing’s self-description as delivering holistic, research-based, patient orientated care. The study consistently refers to the participants’ expression of this approach as ‘their’ ideals, reflecting the internalisation of values that is seen as an integral part of developing professional identity. Within the study, the overt transmission of nursing’s professional values is seen as the province of the university classroom. The practice setting, by contrast, is the site of informal learning.

From their interview data Maben and colleagues propose the existence of four destructive ‘covert rules’ for new nurses, although it is not clear, here and elsewhere, how far the researchers take the respondents’ accounts at face value. These implicit ‘covert rules’ mark a cynical alternative to the profession’s overt values: ‘hurried physical care prevails… no shirking… don’t get involved with patients… fit in and don’t rock the boat’ (Maben et al., 2007 page 103).

Chambliss’ sensitive ethnographic work on ethical decision-making and professional identity in US hospitals in the 1990s (Chambliss, 1996) also focuses on what might be called desensitisation (see the ‘covert rules’ above), though he does not understand this as negative or regrettable for nurses. His conclusion is that in order to work effectively in the healthcare environment, workers have to routinise the traumatic. Part of this routinisation involves, as others who have studied healthcare workers have noted, the sharing of dark, ‘back-stage’ (Goffman, 1959) humour and disparaging labelling of certain classes of patients. The strength of Chambliss’ work is that he does not make moral judgements about this aspect of professional identity and rather understands the function that it serves within healthcare work. Returning to Boys in White, a similar point emerges from Becker *et al.*’s research, that the formation of identity in the professional socialisation processes, can largely be seen as successful because it enables the profession to continue to function with stability (Becker et al., 1961). In summary, much of the nursing literature, in contrast to Chambliss’ work and earlier studies of medical students, concludes that socialisation into professional nursing is deeply problematic because new recruits are pictured as *starting out* as identifying with the professions’ ‘ideals’ but lose this as they enter and continue to work in the profession. This points to a surprising inversion, which is

possibly an effect of researchers of nursing often being drawn from members of that profession, with a perhaps unacknowledged commitment to these ‘ideals’.

Before moving on, we wish to detail some of the current context of healthcare work in the UK NHS because it has a profound effect on the experience of health workers and those in training.

Healthcare scandals in the UK

A series of well-publicised scandals in the UK dating from the 2010s have implicated nursing. The first reports of systematic failures of care at Stafford Hospital appeared during the 2010s, along with harrowing tales of nurses’ apparently cruel behaviour (BBC News, 2010). This was followed by undercover reporting showing brutality to patients (BBC Panorama, 2011), and a report of the Ombudsman (Health Service Ombudsman, 2011) detailing a series of stories of poor nursing of older people. Many other examples have been listed (Delamothe, 2011). This evoked a sense of crisis in the profession and a series of published reaffirmations of the centrality of ‘care’ and ‘compassion’ as part of the ‘six Cs’ (all aspirational positive personal characteristics of nurses—others comprised ‘courage’, ‘competence’, ‘communication’, and ‘commitment’) promoted by the English Chief Nursing Officer (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012; NMC, 2011).

The final report of the Francis inquiry into the Stafford hospital problems included long sections about the failures of nursing (Francis, 2013b). Francis considered that:

> The experience from Stafford… suggests that the current university-based model of training does not focus enough on the impact of culture and caring. It is likely that most of those entering the nursing profession do so because of a wish to undertake

> work helping and caring for others. Even in a well run organisation, the stark differences between nursing as they imagined it to be and the reality will challenge their ability to maintain their motivation. This can be seen even more so in the stresses of working in an understaffed, badly led environment in which the quality of care appears to take a lower priority than throughput and where meeting managerially dictated targets can turn the unacceptable into the mundane. In other words, the internal drive to insist on proper standards of care can all too soon degenerate and be replaced by a meek acceptance of the mediocre or worse. (Francis, 2013b Section 23.48 page 1513).

Our analysis focuses on the early socialisation of students training to become professionally qualified nurses in a context where the profession is under intense public criticism. The data discussed in this paper has a direct relevance to this description of the problem of how new recruits respond to what they consider poor standards of care.

Aims of the research

The central question explored in this paper is what characterises the development of the professional identity of student nurses as they talk about experiences of clinical work in the UK NHS?

Method

Study context

The data presented in this paper were collected as part of on-going research at a London university focussing on professional identity of a range of healthcare workers in training. The research started in 2011 and its aim is to gain an understanding of the next generations of nurses, midwives and support workers in terms of their motivations for training, career expectations, experiences during clinical placements and developing professional identities (Traynor, 2014; Traynor et al., 2015). This particular study concerns

the data from focus groups carried out with students studying on a BSc Nursing course. The interactional features of focus group conversations, where views are potentially challenged, corroborated and/or marginalised, made it an appropriate approach to exploring an occupational group's professional discourse and identity (Bloor et al., 2001).

Sampling

Students undertaking BSc Nursing courses between 2011 and 2014 were invited by the first author to participate in focus groups. The research included students involved in all branches of nurse training (mental health, adult i.e. physical nursing, and children's nursing). The research has involved 4 cohorts of students. To date six groups have been convened involving a total of 49 students, all from either the 2nd or 3rd year of training and so with a moderate level of experience of the workplace.

The numbers participating in each group and total cohort sizes are provided in Table 1. We did not ask participants to provide any demographic information, although we know that 12% of all cohorts currently registered for this course are male and that the mean age is 28.

INSERT TABLE 1 HERE

Focus groups

The groups were moderated by the first author who has no other involvement with these groups and were held in university rooms usually during the lunch break of the students' courses in order to enable participation. They were audio recorded and transcribed in full by an experienced audio typist. The groups lasted between 41 and 60 minutes with a modal value of 50 minutes. A topic guide based on the overall aims of the research was developed. This comprised a question about motivation to undertake the training, what participants looked forward to after qualification, surprises they had encountered in

practice and a final question about decision-making (not considered in this paper). The study received ethical approval from the relevant School ethics committee. Each participant gave signed consent to participate.

Analysis

The analysis of the focus group data was informed by discourse analysis (Potter & Wetherell, 1987), which was appropriate to our interest in the interactional features of the focus groups and speakers' call on already existing and powerful discourses such as that to do with intrinsic moral orientations. We also drew on the ideas of Bucholtz and Hall regarding the emergence of identity from interaction (Bucholtz & Hall, 2005) particularly the notion of identity as emerging through linguistic interaction, rather than being a stable internal psychological structure and a source of linguistic practices. As the group participants negotiated conversational topics they positioned themselves, and others, and took up certain identities. Our theoretical position was that the participants' discussion about negotiation of workplace issues would give insight into the groups' professional identity work. Thus our analytic approach to the texts and our theoretical concept of identity owes something to the ethnomethodological concept of 'doing' various kinds of identity (Garfinkel, 1986)—in this case within the groups—and a broadly post-structuralist theory of performativity regarding identity (Butler, 2005).

First, both authors familiarised themselves with all the transcripts and the first author annotated the focus group transcripts paying particular attention to material that appeared to be relevant to our research interest e.g. participants' statements that link membership of the profession with innate personal qualities. *Second*, after reviewing the theoretical foundation and the quality of the empirical data supporting the themes of interest, the

authors decided to focus on talk dealing with ‘poor nursing care’. This was a prominent theme that seemed to encapsulate key aspects of the nursing students’ professional socialisation and identity work. While working shoulder-to-shoulder in front of the transcripts, the authors listened to the original sound recordings and annotated the full dataset. This highly collaborative approach to data analysis had the potential to strengthen the analysis by, on the one hand, generating new ideas about the dataset, and, on the other, by challenging the individual interpreter’s taken-for-granted ideas. The analytic process led to the description of three dimensions related to ‘poor nursing care’. *Third*, we selected data extracts that appeared to hold interpretive potential e.g. they expressed unusual conflict or seemed to represent an extreme formulation of a position, or appeared ambiguous for further analysis. We then developed more elaborate transcriptions to include basic interactional features where appropriate e.g. where interruption appeared to suggest something about conflicts in identity work in the group. This was the basis for a detailed analysis of how the participants constructed accounts and the possible functions of these particular accounts in the groups (Potter & Wetherell, 1987). *Fourth*, the different parts of the analysis were pulled together and the three dimensions related to ‘poor nursing care’ were more fully developed. Finally, we compared these passages to the original dataset in an attempt to ensure we had developed an interpretation that was not atypical of the data as a whole.

In the results section, we show the dimensions related to ‘poor nursing care’ by presenting analyses of four data extracts. These data extracts are selected as they are highly illustrative, though they do not necessarily account for all aspects of the findings.

Findings

Characteristics of the talk in the groups

Most of the groups featured high degrees of consensus in the ideas expressed and in the identities that were developed. The group members tended to build on the arguments or frame of reference of previous speakers and only one group was characterised by significant disagreement. Often speakers would make a point, to which they would return several times. Many speakers were not native English speakers and used English in slightly unconventional ways. Some speakers referred to their non–Western identity as explanation for their position. It was notable that many group members brought frameworks for sense-making that appeared to have little to do with any formal professional education to the discussion. They rarely referred to the effect of professional mentorship, which some reviews have claimed is a mechanism for 'positive' socialisation, other than in a critical way.

1. Caring is tangible and comes naturally

Many participants told of close family members who were nurses. Some participants regarded nursing as a career opportunity, which was more advantageous compared to other career opportunities. Most participants described their motivation for entering the nursing programme as closely linked to their particular biography and personality. Their decision to enrol was often taken with regard to other family members' concerns and situations. This included, for instance, pragmatic concerns about a stable economy in the family and/or concerns about bringing up small children while studying or formative memories of caring for sick or dying relatives. Furthermore, the accounts of their motivations were also related to personal experiences of nursing work as a tangible and

rewarding everyday activity, which took place in the most proximal relationships, such as serving a cup of tea, helping people getting dressed or talking to people about things that matter to them.

Participants tended to describe nursing work as an expression of innate attributes and their comments were organised round a notion of stable, authentic personal qualities and the resultant motivations. In the following data extract, participant 1responds to the group's discussion of what it means to be a nurse.

Data extract 1. Mental Health Nursing students 3rd year 2013:

Participant 1: I think nursing is who you are and, yeah, the manner in which you go and treat your family or somebody else is the manner you should go inside and treat a patient and we can't all have all these qualities but you use what you have. And that's why sometimes we talk about reflective practice, right. Where you sit back and you think about what you've done and look at different ways of doing it. Done it good, bad and (.) I think it's just, the thing is who you are from within, it's not something that is taught. I can learn about medication and everything else but (.) for me to be a nurse, for me to have it within me, it's me in a way >I don't know< it has to be.

Participant 1 starts out (lines 1-3) by stating that nursing is part of the person and does not distinguish between caring activities in home life and in professional work, which in effect conflates the morality of caring for sick family members and caring for health service patients. Furthermore, participant 1 explains that not everybody has such caring qualities, which is why there is a need to reflect on the qualities of their conduct. The professional concept of reflective practice is described in a common sense way as thoughts about the value of one's actions (lines 5-7). Participant 1 then returns to the point about fundamental personal qualities (lines 8-12) and explains that it is not a technical skill that can be taught but an innate quality. The talk positions the speaker as someone who 'has' these qualities.

Many participants used this form of words and this identification was created across all of the groups. Some participants took this further by identifying the pleasure they experienced at receiving the gratitude and acknowledgement of patients that they had cared for.

2. The good nurse/bad nurse

Because the participants often presented good nursing as an expression of a natural inner quality as we have just shown, their explanation for poor nursing generally reflected the same kind of understanding. 'Bad' nurses were bad because they lacked (or in some cases had lost) the necessary qualities. The participants tended to strongly identify with the 'good nurse'. Their enactment of their ability to recognise bad nursing and their moral outrage at this recognition can be understood as part of their performance of the identity of good nurse. It can also be seen as the enactment of a group identity as students set against the more powerful yet often corrupt 'old guard' of qualified professional nurses. In the following data extract, participant 12 contributes to an on-going discussion of their observations of low levels of care.

Data extract 2. Mixed Physical and Mental Health Nursing Students in 2nd year, Afternoon, February 2014:

Participant 12:It's the level of compassion. Even you are surprised cause thinking that they're already registered and thinking, you know, what we are hearing from the classroom that nursing is about compassion and empathy, sympathy, but when you go out there and see the real nurses, the registered ones, you'd just be surprised, where you, like it seems like, what she said, they're physically there but their minds and hearts are not really for caring. It's quite disappointing.

Others: Yes, yeah

Participant 3: It's almost like literally it's grown out of the nurses.

Participant 12:But looking at their side as well, sometimes there's always two sides of the story. You either hear them complaining that they're short of staff or sometimes overload of work like they're supposed to be on one bay but end up like having two bays. So for them it's very difficult already to cope with one bay, one more additional bay and then lack of healthcare assistants and sometimes, you know, in my placement >you know< I end like being one of the healthcare assistants because I'm literally the only person helping with the qualified nurse; there's no HCA available because they're short of staff. It's a good thing because I have a background in caring but >you know< you can hear these things from them as well. Sometimes you can't blame them, but in a way because we are into nursing and we are (.) and they are nurses, the number one concern is about your compassion. Sometimes, they forget that. They just >you know< they are just burned out.

Participant 12 starts out (lines 1-11), by stating that she finds it surprising that registered nurses act in ways that are in conflict with what is taught in the classrooms. In particular, the surprise is created through a repeated emphasis on the nurses' formal registration, which ought to involve basic nursing values, but does not. Other participants agree to participant 12's statement and participant 3 rephrases the statement by metaphorically describing compassion as having 'grown out' of them.

Participant 12 continues (lines 18-24) by rhetorically inviting the group to look in a more nuanced way at the registered nurses' position. The registered nurses are described as 'complaining', itself a negative depiction, about one of two contextual constraints 'short staffing' and 'overload of work'. These are described as genuine challenges that might explain poor nursing over and above the personal failings of nurses. However, participant 12 continues to position herself (lines 24-29) as a heroic and unfailing hard worker, 'a good nurse' as described above, which in effect distances herself from failing care and

undercuts her own argument for understanding the ‘bad nurse’. She concludes by morally discrediting the registered nurses as ‘burnt out’.

Overall the groups varied regarding their explanations for poor care being individualistic or organisational. In some groups the members mobilised concepts such as shortage of nurses, ‘burnout’, ward leadership and NHS reorganisation alongside more common sense ideas about human motivation. While some groups were characterised by fixed and strong beliefs about this topic others showed more flexibility. In the following extract, the group is discussing reasons for good and bad nursing they had observed on their placements.

Data extract 3. Adult Nurses, 3rd year Group 1, January 2016:

Participant 5: I think it depends on people’s personality and the manager as well. If managers don’t care, then (.)

Participant 2: I think it’s a lot about staffing (.)

Participant 4: Yeah, maybe it’s not about personality but it’s about that they are overwhelmed with work, so they are very nice people and very helpful, but, because they are overwhelmed by work and they are very stressed, they are just. They don’t really bother about having us students, because they have six other patients to look after, so they don’t have time to look after the student.

After this passage in this group, many other participants told stories aiming to illustrate the same point that nurses who initially appeared to be unhelpful turned out to be ‘really’ very compassionate when pressures were lifted from them. In much talk, nurses appeared to identify with patients: qualified nurses had to ‘look after’ both their allocation of patients *and* their student. Good nurses were described as doing both jobs well while bad nurses were ‘uncaring’ towards both. This identification with patients gives a sense of how different the student’s position, identity and power can be from the full member of the profession. This identification points to their sense of vulnerability.

3. Strategies for avoiding becoming the bad nurse

The participants were anxious about becoming rigid and uncaring as a result of working in the NHS and talked about ways they could avoid such professional corruption. The participants told several stories of speaking up against poor nursing and/or unfair demands in their work. Such 'war stories' about the trials they had overcome individually can be regarded as having a social function in the groups in that they depicted the unlikely victories of the nursing students in the challenging clinical milieu.

The following data extract is from a focus group in which many of the participants were energetically critical of most aspects of their experience of clinical placement and highly anxious about their place within hospital ward culture and hierarchy. Prior to the data extract, the moderator asked the group what personal strategies they would use to avoid becoming like the nurses they have been criticising.

Data extract 4. Mixed Adult and Mental Health, 2nd year students February 2014:

Participant 5: What would you really do, you as an individual that's coming onto a new ward and you've got >you know< this group of people >you know< and they've already formed relationships, they've formed their friendships. If anything happens >you know< that one's gonna stick up for that one; they're not gonna have your back cause they don't know you and it takes a long time to kind of settle in with that team.

Participant 4: I think a good strategy is to be interactive in (.) that if you enter this environment, you need to interact yourself with them and then, from then, start making a few changes because you will gain all the trust from the ones around you so then probably start implementing new changes but that can take years.

Participant 5: Yeah

Participant 4: But I think if I entered a place like that I would probably be trying to get good relationships with the team that I work with and then from then, um I

would just be challenging or moving, or changing things >slowly, slowly< because you can't just be, go to the ward and say, ''yeah all right, I don't agree with this'' and then people would start like [((unclear))

Participant 9: [How will you cope though? You go on to a ward, you're there you see something you're not happy with, even if it's just a comment to a patient or another member of staff and you report it or you pull them up on it. And then you're deemed the outsider, you're deemed the stirrer and you're then the outsider of the group, of the shift, every shift, you're excluded. How do you deal with that as a as a human being, not just as nurse, as a human being, thinking back to when you were in school, if you weren't in the in-crowd and >you know< even out with your friends >you know< if you're not always the lively one, how do you deal with that?

Participant 5 responds to the moderator's question by rhetorically asking about nursing students' limited scope for action. She emphasises nursing students' predicament by positioning such a student as an individual in opposition to a group of nurses who will stick together rather than support the student. Furthermore, participant 5 suggests that the formation of groups of nurses has taken place over a long period of time so is all the more strong.

Participant 4 takes over (line 10) and elaborates on participant 5's description of nurses as a forming a closed group. She proposes that it is possible to implement changes by interacting with the group and gradually becoming a member of that group. Participant 5 acknowledges this suggestion (line 17). Participant 4 continues by describing her personal strategy for creating change. She rhetorically downgrades the effectiveness of her strategy by adding that it has to happen ">slowly slowly<" and performs a 1st person enactment of an obviously over-confrontational approach to creating change "yeah all right, I don't agree with this".

Participant 9 interrupts participant 4 with a rhetorical question about nursing students' ability to cope with challenging experienced staff (line 27). Participant 9 also elaborates on participant 5's idea about nursing students having to challenge a group of nurses. She describes the threat of being marginalised. She angrily emphasises her point by asking rhetorical questions that place the issue of being bullied not simply as a problem during clinical placement, but as a general existential problem of being marginalised in a group of peers.

As described in theme 1 above, participants criticised and distanced themselves from qualified nurses whom they described as acting out of expedience, furthering their own interests and neglecting those of patients. However, as indicated in the data extract above, their strategies for avoiding becoming a bad nurse were most often passive and non-confrontational, such as swallowing their principles about how to respond to poor practice. These strategies were chosen in the interests of avoiding exclusion, of being passed on their ward assessments or of avoiding overt conflicts that they were unlikely to come out of successfully.

Another strategy proposed by some participants concerned the introduction of an external authority—they used the example of a matron in the 'old days' who would police the wards and discipline poorly performing and uncaring nurses. Participants looked forward to qualifying, many describing this as

providing them the authority, autonomy and control to care for patients in a manner they would chose.

Discussion

Sociological literature on the development of identity in the healthcare professions emphasises the informal learning that occurs in the workplace. The vulnerability and disorientation experienced by the neophyte in the workplace, leading to the urgent desire to 'fit in', functions as a catalyst for sometimes radical changes in understanding, attitudes and behaviour (Becker et al., 1961). Traditional professional hierarchy combined with the traumatic nature of much healthcare work provides a potent milieu that renders newcomers susceptible to peer and hierarchical influence. But as Chambliss argues, socialisation enables the new professional to survive and to be effective as they learn to routinise the traumatic (Chambliss, 1996).

While there is a body of literature focussing on professional talk and its link with the performance of professional identity (Atkinson, 1995; Atkinson & Heath, 1981; Drew & Heritage, 1992), there is little of such research focussing on professionals talking among themselves or to researchers. The predominant conclusion in literature on developing professional identity in nursing is that exposure to the practice setting evokes distress among those in training for entry to the profession. This distress is said to be a result of a dissonance between the idealism of the neophyte and the apparent depersonalisation and cynicism witnessed in the work of nurses in health service settings. Researchers have identified different responses among students to this: some are disillusioned in their expectations of professional

life because what they witness does not match the values that they believe define nursing while others maintain various levels of ‘idealism’ combined with a more pragmatic approach (Maben et al., 2007). Common in such research is the assumption that the ‘ideals’ with which the profession as a whole identifies concerning compassionate, individualised patient-centred care are the same as those with which the neophyte identifies. There is a tendency to take respondents’ talk about their values at face value. Because of this there is often a sense of regret about socialisation apparent in research on the topic by researchers who perhaps also identify with the same values because they are drawn from the profession (Mackintosh, 2006).

The timing of our research meant that the spectre of highly publicised nurse cruelty haunted the group discussions (Francis, 2013a). Most participants referred to their unease about the profession’s current reputation and to the rhetorical ‘six C’s’ promoted by the UK government’s Chief Nurse (Nursing & Adviser, 2012) in an attempt to reinstate the profession’s identification with various moral goods. This context had the possible effect of heightening the dualism between ‘good’ and ‘bad’ nursing as discussed by participants and also lending legitimacy to their claims to being on the side of caring and compassion.

As with previous research (Maben et al., 2007), our participants gave voice to talk that could at face value be understood as idealistic. There were many strong avowals of the value of care and compassion in the profession and as the basis of their own motivations and experiences. However, participants’

emphasis on caring as an essential trait for the nurse also functions as identity work on the part of a group experiencing anxiety and threat in the workplace and seeking separation (from the oppressor) and solidarity (with each other). Their talk mobilised a number of strong dualisms: the good nurse–with which they identified–and the bad nurse–whom they encountered in hospitals. This in turn gave rise to further dualisms: genuineness—their own practice 'from the heart'–and cynicism–the nurses who are motivated by money alone, and authority and de-legitimacy–the ambivalent identity of the 'real' nurses who are in a position of hierarchical authority over them but have no moral authority, according to their discourse. Their identity, then, as the good nurse or the nurse who cares depends on and takes shape largely from specific encounters (Bucholtz & Hall, 2005) in the health service setting.

Parallel with the talk of idealism, another less frequent kind of performance evident in the groups was one of cynicism. This emerged when participants for example spoke about 'kissing arse', or 'just keep[ing] my head down' in the workplace in order to pass ward assessments and progress on the course. Like Becker's 'Boys in White', these students were prepared to go to great lengths to enter the profession. Another form of cynicism was the denial that they would be able to effect change in practice, as illustrated in our fourth data extract. Despite the fact that this might undermine their previous identifications with the moral 'high ground' of caring and authenticity, participants enacted such positions of cynicism without any modifying talk and were never challenged by other group members. In fact such expressions seemed to be occasions for positive group solidarity as it was widely

recognised that these expressions denoted a posture of sophisticated realism which all were willing to share. We can understand this cynical talk as a temporary role and orientation assumed by participants at particular points in the group discussions with the same aim of defending against the anxiety of a sense of powerlessness regarding their total reliance on professionals to pass the course. Attention to the combination of cynicism, 'humanitarianism' and anxiety has a long history in study of professional socialisation in medicine and nursing, see e.g. (Eron, 1958).

The answers to the moderator's questioning about the causes of bad practice drew out two contradictory explanations that reflected two key aspects of the students' identifications, by which we mean what or who they identified themselves with. One identification was with being an innately caring individual. This gave rise to the explanation that bad practice was a result of nurses lacking this essential quality. The explanation for bad nursing was bad nurses. A second identification was that they were new in the clinical setting. This is reflected in the claim that it was being too long in healthcare that caused corruption. In this explanation bad nurses may have started out good. We suggest that the function in the groups of both explanations is to distance the participants from any possibility that bad practice might be anything that could be associated with them.

As we have said, each group featured high degrees of consensus – participants rarely problematized the utterances of other group members. It could well be that the participants used the focus groups as opportunities to

develop and display solidarity that was a vital part of their identity work, again under the influence of their sense of powerlessness within the professional setting. A similar finding emerged from the study of racial minority groups (Mango, 2010). In a group where one member spoke about structural influences on professional behaviour (see data extract 3) the other participants subsequently produced stories corroborating this position. One group did feature a clear difference of opinion (see data extract 4). The predominant talk in this group was highly cynical about the behaviour of professionals in practice and the consensus was that poor practice and bullying were commonplace making it impossible to influence care. In this instance one participant who suggested that a strategy for change was possible was silenced by hostile responses from other group members in a way that maintained the overall identity of the group as worldly wise and negative about the profession.

Because of the unacknowledged and unresolved contradiction in explanations for poor nursing—that the wrong people were nursing and that the 'right' people had lost their personal qualities without realising it—participants' descriptions of strategies to avoid the same corruption lacked consistency. Some asserted that they would avoid the fate of senior colleagues by an act of will power while others said that they would change job if they felt they were losing compassion. Some looked forward to the appearance of an 'old-fashioned' matron to police the bad nurses. This fantasy of an authoritative moral agent can be seen as a further sign of their position of powerlessness, as 'slaves' in the healthcare hierarchy (Paley, 2002). In some groups students enacted the very behaviour that they criticised in qualified nurses: verbal

bullying and negativity and were open about acting in self-interest rather than behaving with integrity when witnessing what they saw as poor care.

Limitations

Our sample includes only 2nd and 3rd year students because we were interested in hearing from participants with experience of the workplace. Inclusion of inexperienced students, however, would have enabled comparison of their early identity work. The sample was drawn from a single university and although participants' experiences were gained in a number of different NHS settings, students in a different university may have responded differently. Some of the features of observed talk may have been related to the mode of data collection i.e. focus groups rather than specifically to the situation of healthcare professionals in training.

Conclusion

It is a common conclusion in research into professional identity in nursing that the idealism of newcomers often gives way to disillusion while some nurses learn to temper their idealism with practical concerns. There is a tendency in this literature to take students' talk at face value. We suggest that students' strong identification with caring also needs to be understood as a discursive move in response to the anxiety evoked by the practice setting. It is a move that can serve to both distance their identity from senior members of the profession and enact group solidarity. This identification as 'caring' exists alongside an apparently contradictory identification as cynical. Understanding both as a response to anxiety is one way to make sense of this apparent contradiction.

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